MONTANA STATE HOSPITAL
POLICY AND PROCEDURE

Quality Assurance for the Radiology Department

Effective Date: March 15, 2017 **Policy #:** RD-04

I. PURPOSE: To enable the radiology department to provide the highest quality of diagnostic care to Montana State Hospital (MSH) patients; to assure the provision of consistently optimal patient care through evaluation of the clinical performance of all technologists in the department and to reduce or eliminate problems identified by the facility and medical staff, and by evaluation of current activities.

II. POLICY: It is the policy of the MSH Radiology Department to provide a high standard of quality care to MSH patients through participation in a Quality Assurance Program. Goals:

1. Assure identification of major problems affecting patient care.
2. Implement a coordinated problem-solving program designed to assure provision of quality patient care.
3. Provide for evaluation of all departmental programs against clinically valid criteria.
4. Assure problem resolution through use of effective follow up and program evaluation mechanisms.

III. DEFINITIONS:

A. Licensed Independent Practitioner (LIP): an active, provisional or part-time physician or APRN and/or CNS who attends to the care of the patients at MSH.
B. Registered Radiology Technologist (RT): current American Registry of Radiologic Technologists (ARRT) and State of Montana license holder under contract to provide services to MSH.
C. Limited Permit Technologist (LPT): current State of Montana limited permit radiology technologist license.
D. Radiologist: radiologist certified by the American Board of Radiology having a current State of Montana Medical License and is under contract to provide radiology services to MSH.

IV. RESPONSIBILITIES:

A. The Radiologist along with the RT will be responsible for the Quality Assurance Program and ensure the program coincides with the MSH Quality Improvement Program.
B. Director of Quality Improvement will report at the quarterly Governing Body meeting.

V. PROCEDURE:

A. **Scope of Care**: Provide safe, effective, and timely radiographic examinations to MSH patients. To provide the LIP with quality diagnostic films.

B. **Aspects of Care:**

1. Quality images.
2. Patient safety and consideration.
3. Accurate documentation.
4. Equipment maintenance.
5. Patient medical record retention.

C. **Collect and Organize Data for each Selected Indicator**: All relevant sources of information are utilized, including but not limited to medical records, hospital statistical reports, reports from external agencies, patient questionnaire, incident reports, patient complaints, and observation of staff members. Data will be collected on standard forms by staff as assigned by the supervisor.

Data should be obtained on an adequate sample of cases. The time frame for data collection should be appropriate to accomplish the desired goal depending on the aspect of care being monitored. Data may be retroactive or concurrent; monthly or as indicated. Indicators with thresholds exceeding established limits will be studied and all activity will be reported to the Q.A. Committee. Data on other identified indicators will be presented to the Q.A. Committee as appropriate or as deemed necessary for intervention. The Director of Quality Improvement will report at Governing Body quarterly meeting.

D. **Evaluate Care**: When thresholds are exceeded, care will be evaluated in order to identify opportunities to improve care and/or identify cause of any problems or methods.

E. **Problem Resolution**: Action to be taken will be identified from the evaluation process. An action plan will be developed and approved by the Q.A. Committee. The action plan should provide opportunities for improvement, (i.e., education, change in policy, equipment change, staffing, and/or behavior changes).

Approved actions to improve care or to correct identified problems related to Q.A. assessment practices may be initiated by the Q.A. Director. This responsibility may be delegated to the relevant staff in the department if deemed appropriate. Actions and recommendations are communicated to the Q.A. Committee and relevant individuals, and proper documentation is made in the minutes. Assessment of the effectiveness of the actions is made, and improvements are documented.

VI. REFERENCES: None.

VII. COLLABORATED WITH: Director of Quality Improvement; Registered Radiology Technologist; Limited Permit Radiology Technologist, Associate Director of Nursing; Medical Director; and Radiologist.

VIII. RESCISSIONS: None, new policy.

IX. DISTRIBUTION: All hospital policy manuals

X. ANNUAL REVIEW AND AUTHORIZATION: This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.

XI. FOLLOW-UP RESPONSIBILITY: Medical Director

XII. ATTACHMENTS: None.

_____/___/__	_____/___/__
Jay Pottenger Date	Thomas Gray, M.D. Date
Hospital Administrator	Medical Director